BEFORE THE
PHYSICIAN ASSISTANT BOARD
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
LAURO IVAN ARTEAGA, P.A.	)	Case No. 950-2015-000656
Physician Assistant License No. PA 13931	)	
Respondent	)	

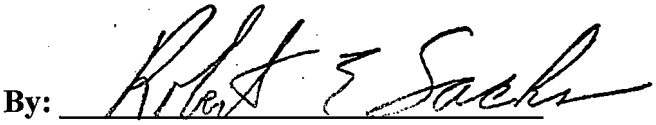
DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Physician Assistant Board, Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 13, 2018.

IT IS SO ORDERED March 15, 2018.

PHYSICIAN ASSISTANT BOARD

By: 

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BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LAURO IVAN ARTEAGA, P.A.** **510 S. Alvarado Street** **Los Angeles, CA 90057** **Physician Assistant License No. PA13931,** Respondent.	Case No. 950-2015-000656 OAH No. 2017080021 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Maureen L. Forsyth (Complainant) is the Executive Officer of the Physician Assistant Board (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Beneth A. Browne, Deputy Attorney General.

2. Respondent Lauro Ivan Arteaga, P.A. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, whose address is: 5440 Trabuco Road, Irvine, CA 92620.

3. On or about January 9, 1997, the Board issued Physician Assistant License No. PA13931 to Respondent. The Physician Assistant License was in full force and effect at all times

relevant to the charges brought in Accusation No. 950-2015-000656, and will expire on December 31, 2018, unless renewed.

JURISDICTION

4. Accusation No. 950-2015-000656 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 1, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 950-2015-000656 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 950-2015-000656. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 950-2015-000656, if proven at a hearing, constitute cause for imposing discipline upon his Physician Assistant License.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual

basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 950-2015-000656 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

12. Respondent agrees that his Physician Assistant License is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CIRCUMSTANCES IN MITIGATION

13. Respondent has never been the subject of any disciplinary action. He is admitting responsibility at an early stage in the proceedings.

CONTINGENCY

14. This stipulation shall be subject to approval by the Physician Assistant Board. Respondent understands and agrees that counsel for Complainant and the staff of the Physician Assistant Board may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

1. IT IS HEREBY ORDERED that Physician Assistant License No. PA13931 issued to Respondent Luaro Ivan Arteaga is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

2. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. The course shall be Category I certified, limited to classroom, conference, or seminar settings. Respondent shall successfully complete the course within the first 6 months of probation.

Respondent shall pay the cost of the course.

Respondent shall submit a certification of successful completion to the Board or its designee within 15 days after completing the course.

3. EDUCATION COURSE Within 60 days of the effective date of the decision, respondent shall submit to the Board or its designee for its prior approval an educational program or course from an accredited program which shall not be less than 40 hours of Category 1 CME. The education course shall be aimed at correcting any areas of deficient practice or knowledge. The course shall be Category I certified, limited to classroom, conference, or seminar settings. Respondent shall successfully complete the course within the first year of probation.

Respondent shall pay the cost of the course.

Respondent shall submit a certification of successful completion to the Board or its designee within 15 days after completing the course.

4. CLINICAL TRAINING PROGRAM Within 60 days of the effective date of this decision, respondent shall submit to the Board or its designee for prior approval, a clinical training or educational program such as the Physician Assessment and Clinical Education Program (PACE) offered by the University of California – San Diego School of Medicine or

equivalent program as approved by the Board or its designee. The exact number of hours and specific content of the program shall be determined by the Board or its designee. The program shall determine whether respondent has successfully completed and passed the program.

Respondent shall pay the cost of the program.

If the program makes recommendations for the scope and length of any additional educational or clinical training, treatment for any medical or psychological condition, or anything else affecting respondent's practice as a physician assistant, respondent shall comply with the program recommendations and pay all associated costs.

Respondent shall successfully complete and pass the program not later than six months after respondent's initial enrollment. The program determines whether or not the respondent successfully completes the program.

If respondent fails to either 1) complete the program within the designated time period, or 2) to pass the program, as determined by the program, respondent shall cease practicing as a physician assistant immediately after being notified by the Board or its designee.

5. ETHICS COURSE Within 60 days of the effective date of this decision, respondent shall submit to the Board or its designee for its prior approval a course in ethics. The course shall be limited to classroom, conference, or seminar settings. Respondent shall successfully complete the course within the first year of probation.

Respondent shall pay the cost of the course.

Respondent shall submit a certification of successful completion to the Board or its designee within 15 days after completing the course.

6. MAINTENANCE OF PATIENT MEDICAL RECORDS

Respondent shall keep written medical records for each patient contact (including all visits and phone calls) at the worksite and shall make them available for immediate inspection by the Board or its designee on the premises at all times during business hours.

7. ON-SITE SUPERVISION

The supervising physician shall be on site at least 30% of the time respondent is practicing.

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8. APPROVAL OF SUPERVISING PHYSICIAN Within 30 days of the effective date of this decision, respondent shall submit to the Board or its designee for its prior approval the name and license number of the supervising physician and a practice plan detailing the nature and frequency of supervision to be provided. Respondent shall not practice until the supervising physician and practice plan are approved by the Board or its designee.

Respondent shall have the supervising physician submit quarterly reports to the Board or its designee.

If the supervising physician resigns or is no longer available, respondent shall, within 15 days, submit the name and license number of a new supervising physician for approval. Respondent shall not practice until a new supervising physician has been approved by the Board or its designee.

9. NOTIFICATION OF EMPLOYER AND SUPERVISING PHYSICIAN Respondent shall notify his/her current and any subsequent employer and supervising physician(s) of the discipline and provide a copy of the Accusation, Decision, and Order to each employer and supervising physician(s) during his/her period of probation, before accepting or continuing employment. Respondent shall ensure that each employer informs the Board or its designee, in writing within 30 days, verifying that the employer and supervising physician(s) have received a copy of the Accusation, Decision, and Order.

This condition shall apply to any change(s) in place of employment.

The respondent shall provide to the Board or its designee the names, physical addresses, mailing addresses, and telephone numbers of all employers, supervising physicians, and work site monitor, and shall inform the Board or its designee in writing of the facility or facilities at which the person practices as a physician assistant.

Respondent shall give specific, written consent to the Board or its designee to allow the Board or its designee to communicate with the employer, supervising physician, or work site monitor regarding the licensee's work status, performance, and monitoring.

10. OBEY ALL LAWS Respondent shall obey all federal, state, and local laws, and all rules governing the practice of medicine as a physician assistant in California, and remain in full

compliance with any court ordered criminal probation, payments, and other orders.

11. QUARTERLY REPORTS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board or its designee, stating whether there has been compliance with all the conditions of probation.

12. OTHER PROBATION REQUIREMENTS Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board and probation unit informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board and probation unit. Under no circumstances shall a post office box serve as an address of record, except as allowed by California Code of Regulations 1399.523.

Respondent shall appear in person for an initial probation interview with Board or its designee within 90 days of the decision. Respondent shall attend the initial interview at a time and place determined by the Board or its designee.

Respondent shall, at all times, maintain a current and renewed physician assistant license.

Respondent shall also immediately inform the probation unit, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

13. INTERVIEW WITH MEDICAL CONSULTANT Respondent shall appear in person for interviews with the Board's medical or expert physician assistant consultant upon request at various intervals and with reasonable notice.

14. NON-PRACTICE WHILE ON PROBATION Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not practicing as a physician assistant. Respondent shall not return to practice until the supervising physician is approved by the Board or its designee.

If, during probation, respondent moves out of the jurisdiction of California to reside or practice elsewhere, including federal facilities, respondent is required to immediately notify the Board in writing of the date of departure and the date of return, if any.

Practicing as a physician assistant in another state of the United States or federal jurisdiction while on active probation with the physician assistant licensing authority of that state or jurisdiction shall not be considered non-practice.

All time spent in a clinical training program that has been approved by the Board or its designee, shall not be considered non-practice. Non-practice due to a Board ordered suspension or in compliance with any other condition or probation, shall not be considered a period of non-practice.

Any period of non-practice, as defined in this condition, will not apply to the reduction of the probationary term.

Periods of non-practice do not relieve respondent of the responsibility to comply with the terms and conditions of probation.

It shall be considered a violation of probation if for a total of two years, respondent fails to practice as a physician assistant. Respondent shall not be considered in violation for non-practice as long as respondent is residing and practicing as a physician assistant in another state of the United States and is on active probation with the physician assistant licensing authority of that state, in which case the two-year period shall begin on the date probation is completed or terminated in that state.

15. UNANNOUNCED CLINICAL SITE VISIT The Board or its designee may make unannounced clinical site visits at any time to ensure that respondent is complying with all terms and conditions of probation.

16. CONDITION FULFILLMENT A course, evaluation, or treatment completed after the acts that gave rise to the charges in the accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of the condition.

17. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., cost recovery, probation costs) no later than 60 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's license will be fully restored.

18. VIOLATION OF PROBATION If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

19. COST RECOVERY The respondent is hereby ordered to reimburse the Physician Assistant Board the amount of $12,658.50 within 90 days from the effective date of this decision for its investigative costs. Failure to reimburse the Board's costs for its investigation shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his responsibility to reimburse the Board for its investigative costs.

20. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. The costs shall be made payable to the Physician Assistant Board and delivered to the Board no later than January 31 of each calendar year.

21. VOLUNTARY LICENSE SURRENDER Following the effective date of this probation, if respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, respondent may request, in writing, the voluntarily surrender of respondent's license to the Board. Respondent's written request to surrender his or her license shall include the following: his or her name, license number, case number, address of record, and an explanation of the reason(s) why respondent seeks to surrender his or her license. The Board reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Respondent shall not be relieved of the requirements of his or her probation unless the Board or its designee notifies respondent in writing that respondent's request to surrender his or her license has been accepted. Upon formal acceptance of the surrender, respondent shall, within 15 days, deliver respondent's wallet and wall certificate to the Board or its designee and shall no longer practice as a physician assistant. Respondent will

no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a physician assistant license, the application shall be treated as a petition for reinstatement of a revoked license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician Assistant License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Physician Assistant Board.

DATED: 01/22/18

LAURO IVAN ARTEAGA, P.A.
Respondent

I have read and fully discussed with Respondent LAURO IVAN ARTEAGA, P.A. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: January 22, 2018

RAYMOND J. MCMAHON
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Physician Assistant Board.

Dated: January 22, 2018

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

Beneth A Browne

BENETH A. BROWNE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 950-2015-000656

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BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LAURO IVAN ARTEAGA, P.A.** **510 S. Alvarado Street** **Los Angeles, CA 90057** **Physician Assistant License No. PA13931** Respondent.	Case No. 950-2015-000656 **ACCUSATION**

Complainant alleges:

PARTIES

1. Maureen L. Forsyth (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs.

2. On or about January 9, 1997, the Physician Assistant Board issued Physician Assistant License Number PA13931 to Lauro Ivan Arteaga, P.A. (Respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Physician Assistant Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 3527 of the Code states, in relevant part:

"(a) The board may order the . . . suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

". . . .

"(f) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

". . . ."

5. Section 2234 of the Code, a part of the Medical Practice Act, states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a

reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

". . . ."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 125.3 of the Code provides, in pertinent part, that "[e]xcept as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department . . . , the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

FACTS

8. At all times relevant to this matter, Respondent was licensed and practicing as a physician assistant in Los Angeles, California.

PATIENT P-1[1]

9. Respondent was the primary medical care provider for Patient P-1, a 74 year old man, for a period that included October 2011 through December 2014. On October 7, 2011, P-1, then 69 years old, saw Respondent to, according to the medical chart, follow up on his previous visit and get a flu shot. There was no further documented history or documented medication list for this visit. P-1's blood pressure was noted to be 160/90 and a glucose check reflected a high blood glucose level of 262. Respondent's assessments for this visit were essential hypertension, type 2 diabetes mellitus, uncomplicated and controlled, and the need for a flu shot. He was advised to return in four weeks. A hemoglobin A1C test to determine what percent of P-1's hemoglobin was

[1] The patients are designated in this document as Patients P-1 through P-6 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

glycated was ordered at that visit. The test revealed a level of 12.6% reflecting a very poorly controlled type 2 diabetes. The notes for P-1's next visit with Respondent on October 22, 2011, for a vital sign check and refill of medications reflect no discussion of the A1C test results.

10. Respondent saw P-1 again on June 12, 2012, to follow up on his previous visit. He complained of a rash on his right chest for four days. There was no further documented history and the physical examination was normal except to note that P-1 had dry skin on his chest and that the area was tender to palpation. There was no glucose check and no discussion of the previous high A1C test results. The assessments were again essential hypertension and type 2 diabetes mellitus, uncomplicated and controlled, with the addition this time of herpes zoster (shingles). Respondent prescribed Zovirax[2] 800 mg every six hours, ibuprofen[3] 600 mg four times daily, and Calamine lotion[4] twice daily.

11. Respondent saw P-1 several more times in 2012 and 2013 and for none of these visits did he document a full history. When he saw P-1 on April 1, 2013, a month after lab tests reflected an out of control hemoglobin A1C result of 11.5%, a micro albumin[5] level of 27.5, and glucose of 172, Respondent did not document a history and once again, despite the lab results, described P-1's type 2 diabetes mellitus as uncomplicated and controlled.

12. Respondent saw P-1 several more times in 2013 and 2014 and for none of the visits did he document a full history, generally noting only the equivalent of "here for f/u previous visit." The records do not include a medication list or discussions of whether P-1 was adhering to the various treatment plans.

13. On May 23, 2013, Respondent added benazepril, an angiotensin converting enzyme (ACE) inhibitor, to P-1's medication regimen to control blood pressure and continued prescribing

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[2] Zovirax is a trade name for acyclovir. Zovirax, an antiviral drug, is a dangerous drug as defined in section 4022. It slows the growth and spread of the herpes virus in the body and can lessen the symptoms of the infection.

[3] Ibuprofen is a nonsteroidal anti-inflammatory drug (NSAID). Ibuprofen works by reducing hormones that cause inflammation and pain in the body.

[4] Calamine lotion is an over the counter medication used to treat mild itchiness from sunburn, insect bite, or other mild skin conditions. It may also help dry out skin irritation.

[5] Micro albumin is a small protein abnormally found in the urine which indicates the earliest signs of diabetes-related kidney damage.

Losartan, an angiotensin II receptor antagonist. Although it is recommended that combining ACE inhibitors and angiotensin receptor blockers be avoided because of the high risk of abnormal potassium levels and other complications, he continued prescribing these two medications together without consulting with a nephrologist or discussing it with his supervising physician.

14. On October 17, 2013, Respondent saw P-1 for a blood pressure check and medication refill. There was an undocumented medication dosage change and no follow up plan was documented. P-1 returned the next day. The only history documented on October 18, 2013, was "here for f/u previous visit." After a normal physical examination, Respondent ordered blood tests and a nutrition class and, although no bone or joint pain was documented, Respondent now diagnosed P-1 with osteoarthritis and generalized arthritis in addition to essential hypertension and type 2 diabetes mellitus, uncomplicated and controlled.

15. On May 4, 2014, Respondent documented the reason for P-1's visit as blurred vision and a swollen left hand with redness. No visual acuity test or examination of P-1's left hand was documented. P-1's blood pressure was noted to be 199/110 and his glucose level 428. Glucose at home was described as "hi, hi, hi." Respondent's assessments were essential hypertension, type 2 diabetes mellitus, uncomplicated and controlled, and osteoarthritis. Respondent's plan was Naproxen, a non-steroidal anti-inflammatory drug, for arthritis; laboratory tests; a diabetic diet and nutrition class; and referral to an ophthalmologist (urgently). P-1 was instructed to return in 4-6 weeks.

16. P-1 saw Respondent several more times in 2014. As before, the chart notes do not include adequate histories or comments on medication compliance.

17. Respondent did not document a visit with P-1 between January 2014 and May 2014 but on or about April 23, 2014, Respondent filled out an N-648 form for P-1. The N-648 form is a Medical Certification for Disability Exceptions for the Department of Homeland Security exempting applicants for United States citizenship from having to take the English and/or civics components of the citizenship test due to a physical or developmental disability or mental impairment that has lasted or is expected to last twelve months or more. On this form, Respondent listed "memory deficit" as a clinical diagnosis based on a mini-mental status exam

(MMSE) dated April 22, 2014, on which P-1's score was 19/30, indicating a severe impairment. Respondent did not document an MMSE in any of P-1's chart notes.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Lack of Knowledge, Failure to Maintain Adequate Records)

18. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) (gross negligence), (c) (repeated negligent acts), and/or (d) incompetence, and section 2266 (inadequate records) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent failed to include complete medical histories and accurate medication lists for Patient P-1, failed to write a thorough narrative of how P-1 was managing his high blood pressure and diabetes, and listed assessments such as osteoarthritis that were not supported by any historical or physical examination information.

B. Respondent failed to adequately address P-1's severe elevations of blood sugar and blood pressure, failed to recognize that P-1's blood sugar was out of control, and combined an ACE inhibitor with an angiotensin receptor blocker without proper consultation and monitoring.

C. Respondent diagnosed P-1 with herpes zoster when the description of the condition was not consistent with herpes zoster and continued ineffective treatment without seeking input from his supervising physician.

D. When P-1 presented with blurry vision, Respondent did not document a visual acuity examination and did not take reasonable steps to lower the critically high blood sugar or the severe elevation of blood pressure which may have contributed to the blurry vision.

E. Respondent described P-1 as having an irreversible memory deficit based on a mini-mental status exam but performed no laboratory or imaging workup for dementia and did not take steps to have him seen by a specialist.

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PATIENT P-2

19. Respondent saw Patient P-2, a 70 year old woman, a total of at least fourteen times between June 11, 2012, when he first saw her, and December 1, 2014. Respondent's history of his first visit with P-2 provides that she had come for a medication review ("id meds"), had a history of hypertension, and that her "vital sign noted bradycardia." No further history was documented and there was no documented medication list. The physical examination was described as normal including the heart exam which, despite P-2's 42 beats per minute heart rate (bradycardia), was noted to have a regular rate and rhythm. Respondent's assessments were "rhythm disorder," "essential hypertension," and "sinus bradycardia." Respondent consulted with a physician who recommended transferring P-2 to the hospital for further evaluation. After evaluation, P-2's blood pressure medication was switched from atenolol, a beta-blocker that slows the heart rate as it lowers blood pressure.

20. P-2's next visit was a week later on June 19, 2012. Respondent documented an extensive review of systems and a normal physical exam but did not document P-2's vital signs or follow up on her hypertension and previous bradycardia.

21. P-2 saw Respondent on January 7, 2013, complaining of a cough for four weeks. The only history documented is the existence of the cough with "no fever, no n/v/d [nausea/vomiting/diarrhea]." The physical exam and vital signs were normal but there was no complete HEENT [Head, Eye, Ear, Nose and Throat] evaluation and the pharynx and neck were not examined. Respondents assessments were cough, essential hypertension, and upper respiratory infection. He injected P-2 with dexamethasone[6] and prescribed Phenergan[7] cough syrup.

22. Respondent saw P-2 again on March 11, 2013, for memory deficit and follow up blood work. Other than stating these reasons for the visit, the only other history documented is

[6] Dexamethasone is a type of steroid medication. It is used in the treatment of many conditions, including allergic reactions, upper airway swelling, and asthma. It is a dangerous drug as defined in section 4022.

[7] Phenergan is a trade name for promethazine, an antihistamine which is used, among other things, as a sedative and to treat allergies and control nausea and vomiting. It is a dangerous drug as defined in section 4022.

"no fever, no n/v/d." There is no active medication list. Respondent did not document a mini-mental status exam or other cognitive function evaluation or a referral to a neurologist. Although Respondent diagnosed P-2 with osteoarthritis, generalized osteoarthritis, and backache, he did not document any painful conditions in his history or his physical exam and did not document an examination of P-2's back.

23. Respondent saw P-2 several more times in 2013 and 2014 and for none of the visits did he document a full history. Nor do the records typically include a medication list.

24. P-2 saw Respondent on June 17, 2013, for a follow up visit after seeing him for a cough on May 13, 2013. Respondent's history for P-2 on June 17th was follow up visit, no fever, less cough, negative chest x-ray, and "pt is unable to learn questionary [*sic*] for u.s. citizenship." Memory deficit was among Respondent's assessments for P-2 on this visit but he did not document an MMSE or other cognitive function evaluation and did not refer P-2 to a neurologist. Left foot pain for which Respondent prescribed tramadol[8], an opioid pain medication, was also among his assessments although he did not mention foot pain in his history and did not document an examination of P-2's foot.

25. On August 14, 2013, Respondent again noted "pt is unable to learn questionary [*sic*] for U.S. citizenship interview" and again diagnosed her with memory deficit although there is still no assessment of memory in the chart and no MMSE score. Respondent's plan reflects an intent to do an MMSE and a neurology referral but there is no evidence that the MMSE was given or the referral made.

26. On P-2's visit of April 8, 2014, Respondent documented several previously unnoted past medical history elements including a history of head trauma at the age of 12 or 13, the development of hearing deficit years after the head trauma, hearing aids at the age of 30, a 6th grade education in Guatemala, inability to read or write in English, and forgetfulness including sometimes forgetting where she left her glasses. His diagnoses included "mild memory

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[8] Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Tramadol is a Schedule IV controlled substance and is a dangerous drug as defined in section 4022.

disturbance following organic brain damage" and his plan included referral to a neurologist and an MMSE.

27. Respondent filled out a Department of Homeland Security N-648 form for Patient P-2 on or about April 14, 2014. On this form, Respondent listed "memory deficit" as a clinical diagnosis based on an MMSE (mini mental status exam) dated April 8, 2014, on which P-2's score was 19/30, indicating a severe impairment. Although the N 648 form states that P-2 was being referred to a neurologist for a dementia work up, there is no evidence of such a work up in P-2's chart.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Failure to Maintain Adequate Records)

28. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) (gross negligence) and/or (c) (repeated negligent acts), and section 2266 (inadequate records) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent failed to include medical histories in P-2's chart specific enough to describe her condition or status and failed to include accurate medication lists and listed assessments such as osteoarthritis and foot pain that were not supported by any historical or physical examination information.

B. Respondent failed to re-evaluate P-2 and check her vital signs to ensure a return to normal heart rate when he saw her a week after she had been diagnosed with profound bradycardia.

C. Respondent failed to fully evaluate P-2 when she presented on January 7, 2013, with a four week history of cough, did not document a complete and accurate history and an examination of P-2's neck and pharynx, and injected P-2 with dexamethasone without documentation of a basis for its use.

D. P-2 reported memory deficit on March 11, 2013, and Respondent diagnosed P-2 with memory deficit on June 17, 2013, but he did not document an MMSE or other cognitive function evaluation or substantiating evidence such as abnormal brain imaging to support the diagnosis

and did not refer P-2 to a neurologist.

E. Although P-2 presented on June 17, 2013, with foot pain so significant that Respondent prescribed an opioid medication to control it, Respondent failed to document a history of the pain and failed to perform a physical evaluation of P-2's foot.

PATIENT P-3

29. Respondent first saw Patient P-3, a 62 year old man, on December 30, 2013. P-3 had been diagnosed with a moderately differentiated adenocarcinoma of the colon earlier in 2013 and had undergone low anterior resection surgery and colostomy[9] placement. Respondent saw P-3 a total of approximately 8 times between December 30, 2013, and November 19, 2014.

30. When P-3 presented on December 30, 2013, Respondent documented his chief complaint as follow up and a history of anus pain and colostomy secondary to colon cancer. Respondent did not document any additional history. The reason for the visit is noted to be a medication review ("id meds"). There was no documented evaluation of the colostomy site and no evaluation of the anus or surrounding area.

31. P-3 saw Respondent again on February 27, 2014, 2 days after having seen a urologist for pain with urination. P-3's reason for seeing Respondent was pain in the anus-rectal area. There is no additional history, no anorectal examination, and no examination of the colostomy site. Respondent did not consult with a supervising physician.

32. On March 27, 2014, P-3 saw Respondent to obtain laboratory results and refill his medications and with documented complaints of memory deficit and limited education and knowledge of English. Respondent described the reasons for the visit as "pt was seen at USC (urologist) because anus pain" and difficulty urinating. The physical exam includes a normal abdominal exam but does not reflect an examination of P-3's rectal area. Respondent diagnosed P-3 with memory deficit on this visit but did not document an MMSE or other cognitive function evaluation and did not refer P-3 to a neurologist.

33. P-3 saw Respondent again on April 10, 2014, for follow up after being seen at the

[9] An artificial opening in the abdominal wall where the colon is diverted so as to bypass a damaged part of the colon.

emergency department of Centinela Hospital where an abdominal CT scan was done because of abdominal pain which reflected a metastasis to the left side of the sacrum. Respondent refilled P-3's Norco[10] prescription and requested an ASAP referral to oncology. Respondent did not mention an MMSE and his diagnoses at this visit did not include memory deficit.

34. Respondent filled out a Department of Homeland Security N-648 form for Patient P-3 on or about April 23, 2014. On this form, Respondent listed "memory deficit" as a clinical diagnosis based on an MMSE (mini mental status exam) dated April 10, 2014, on which P-3's score was 20/30, indicating a severe impairment. Although the N 648 form states that P-3 was being evaluated and would be referred to a neurologist for a complete work up of his memory deficit, there is no evidence of an evaluation or a neurology referral in P-3's chart.

35. P-3 saw the oncologist who confirmed a recurrence of his colon cancer

36. On May 21, 2014, P-3 presented to Respondent after having been treated at the hospital for acute urinary retention. Respondent diagnosed him with benign prostatic hypertrophy without urinary obstruction and advised him to return to the clinic in one week to have a urinary bladder catheter removed. P-3 followed up on May 27, 2014, and Respondent removed the urinary catheter and P-3 was able to urinate without difficulty.

THIRD CAUSE FOR DISCIPLINE
(Gross Negligence, Repeated Negligent Acts)

37. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) (gross negligence) and/or (c) (repeated negligent acts), of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent failed to document an adequate history when P-3 presented with rectal pain in December 2013 and February and March 2014, failed to do a rectal exam or examine P-3's rectal area to determine if he had an anus and rectum to examine, failed to evaluate the

[10] Norco is a trade name for hydrocodone, an opioid pain medication, with acetaminophen. It is used to treat moderate to moderately severe pain. Norco is a Schedule II controlled substance and is a dangerous drug as defined in section 4022.

colostomy, and failed to consult with his supervising physician.

B. Respondent failed to perform an adequate cognitive evaluation of P-3, a high risk cancer patient, when he presented on March 27, 2014, with a complaint of memory deficit or when, after receiving evidence that P-3 had metastatic cancer, and MMSE performed on April 10, 2014, reflected severe cognitive impairment.

PATIENT P-4

38. Respondent saw Patient P-4, a 58 year old woman, twice: March 10, 2014, and March 17, 2014. On March 10th, P-4 presented with a chief complaint of right shoulder pain after a fall three weeks earlier. She also complained of memory deficit and inability to read and speak English. Respondent provided no further history of the fall or the injury and no documented direct physical exam evaluation of P-4's shoulder. Respondent's assessments included memory deficit and right shoulder pain and his plan included referral to a neurologist and an MMSE in addition to various lifestyle recommendations.

39. Respondent saw P-4 the following week, on April 17, 2014, for a follow up. Under "Reason for Visit," Respondent only listed information about P-4's lack of education, inability to read and write English, and inability to retain new information. Respondent's assessments included memory deficit and his plan again included referral to a neurologist and an MMSE although neither are documented in P-4's chart.

40. Respondent filled out a Department of Homeland Security N-648 form for Patient P-4 on or about April 23, 2014. On this form, Respondent listed "memory deficit" as a clinical diagnosis based on an MMSE dated April 14, 2014, on which P-4's score was 20/30, indicating a severe impairment. Although the N-648 form states that P-4 was being referred to a neurologist for a complete work up of her memory deficit, there is no evidence of such a work up in P-4's chart. In addition, Respondent listed a diagnosis of epilepsy for P-4 in the N-648 form although there is no indication in her chart or elsewhere that she had epilepsy. When asked, Respondent admitted that the inclusion of the epilepsy diagnosis was an error which he attributed to his having cut and pasted some of the narrative information in the form.

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FOURTH CAUSE FOR DISCIPLINE
(Gross Negligence, Repeated Negligent Acts)

41. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) (gross negligence) and/or (c) (repeated negligent acts), of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent failed to fully evaluate P-4 when she presented with shoulder pain after a fall, failing to document the circumstances of the fall and the extent or nature of the injury.

B. When P-4 complained of a memory deficit on April 10, 2014, Respondent diagnosed her with memory deficit but did not document in her chart an MMSE or other cognitive function evaluation or substantiating evidence such as abnormal brain imaging to support the diagnosis and did not refer P-4 to a neurologist.

PATIENT P-5

42. From at least February 2013 through September 2014, Patient P-5, a 79 year old woman, received medical treatment at the clinic where Respondent was employed. Except for a Homeland Security N-648 form Respondent filled out for her, there is no documentation that she was ever seen by Respondent.

43. Respondent filled out a Department of Homeland Security N-648 form for Patient P-5 on or about April 23, 2014. On this form, Respondent listed "memory deficit" as a clinical diagnosis based on an MMSE dated April 10, 2014, on which P-5's score was 19/30, indicating a severe impairment. There is no evidence in P-5's chart that she suffered from memory deficit and, although the N-648 form states that P-5 was being referred to a neurologist for a complete work up of her memory deficit, there is no evidence in P-5's chart of a referral to a neurologist or any work up of P-5's cognitive impairment. In addition, Respondent listed a diagnosis of epilepsy for P-5 in the N-648 form although there is no indication in her chart or elsewhere that she had epilepsy. When asked, Respondent admitted that the inclusion of the epilepsy diagnosis was an error which he attributed to his having cut and pasted some of the narrative information in the form.

FIFTH CAUSE FOR DISCIPLINE
(Gross Negligence, Repeated Negligent Acts)

44. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) (gross negligence) and/or (c) (repeated negligent acts), of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent failed to arrange for a neurological work up for P-5 despite his having administered an MMSE to her the results of which indicated a severe cognitive impairment.

PATIENT P-6

45. Respondent was the primary medical care provider for Patient P-6, a 74 year old woman, for a number of years including the period from January 27, 2012, through December 4, 2014.

46. On June 12, 2012, P-6, then 69 years old, saw Respondent for follow up on blood work and "frequent acidity on stomach." He noted that she had no fever, nausea, vomiting, or diarrhea. There was no further clarification of symptoms or documented history for this visit. P-6 had a normal physical examination except for a glucose level of 233. Respondent's assessments were essential hypertension, gastritis, and type 2 diabetes mellitus, uncomplicated and controlled. He prescribed, among other things, diclofenac[11] for arthritis, metformin[12] for diabetes, and omeprazole[13] for stomach acid. Blood tests were ordered and P-6 was told to avoid chilies in her diet. The blood tests showed P-6's diabetes to be out of control with a hemoglobin A1C level of 8.6%.

47. After visits for medication refills, P-6 next saw Respondent on January 20, 2013,

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[11] Diclofenac is a nonsteroidal anti-inflammatory drug (NSAID). It is used to treat mild to moderate pain or signs and symptoms of osteoarthritis or rheumatoid arthritis. Diclofenac may cause stomach or intestinal bleeding, which can be fatal. These conditions can occur without warning, especially in older adults. Diclofenac is a dangerous drug as defined in section 4022.

[12] Metformin is the first-line medication for the treatment of type 2 diabetes. Common side effects include diarrhea, nausea, and abdominal pain. Metformin is a dangerous drug as defined in section 4022.

[13] Omeprazole, also known by the trade name Prilosec, belongs to group of drugs called proton pump inhibitors. It decreases the amount of acid produced in the stomach.

because she had fallen 10 days before and struck her left eye and frontal area and was experiencing mild dizziness and a light headache. She denied loss of consciousness. Respondent documented no further history including the circumstances surrounding the fall. There is no medication list. Physical examination revealed bruising on the left side of the face and frontal area. A neurological exam is not documented. Diclofenac is not mentioned and ibuprofen, another nonsteroidal anti-inflammatory drug, was prescribed for pain. There was no glucose check and no discussion of the previous high A1C test results. Respondent's assessments again included essential hypertension and type 2 diabetes mellitus, uncomplicated and controlled.

48. P-6 presented next on February 17, 2013, complaining of fine trembling of her upper extremities with voluntary movement for two months. Documentation of a neurological exam states only "fine movements of upper extremities." Respondent's assessments included "fine movement of upper extremities (r/o parkinson disease)" and his plan included a neurological referral although there is no evidence of a neurologist evaluation in P-6's file and no discussion of it on subsequent visits.

49. When P-6 saw Respondent on October 4 and 17, 2013, for medication refills, there was no discussion of P-6's current status and no discussion of P-6's tremor. On October 18, 2013, P-6 saw Respondent for a follow up. Although a glucose level of 263 was documented and her last A1C test results were 8.6%, Respondent again described P-6's diabetes as uncomplicated and controlled. A blood test ordered on October 18th came back with an A1C of 8.8%, again revealing out of control diabetes. This was not discussed when P-6 returned on January 16, 2014, for a medication refill.

50. On April 6, 2014, P-6 saw Respondent with a chief complaint of abdominal pain for three days. The extent of the history is "LLQ pain x 4 days, no fever, no n/v/d." The history of present illness states "no gastrointestinal symptoms," the review of systems states "no abdominal pain," and the physical examination of the abdomen is described as completely normal with no tenderness to palpation yet abdominal pain was among Respondent's assessments. His plan was

for P-6 to take Flagyl[14] 500 mg twice daily for 10 days. He explained later that the Flagyl was to treat possible colitis. The A1C test ordered that day came back at 9.0%. There is no documentation of any memory problems or MMSE in P-6's chart notes for this date or any other date.

51. Respondent filled out a Department of Homeland Security N-648 form for Patient P-6 on or about April 6, 2014. On this form, Respondent listed "memory deficit" as a clinical diagnosis based on an MMSE dated April 6, 2014, on which P-6's score was 19/30, indicating a severe impairment. Although the N-648 form states that P-6 was being referred to a neurologist for a complete work up of her memory deficit, there is no evidence of such a work up in her chart. In addition, Respondent listed a diagnosis of epilepsy for P-6 in the N-648 form although there is no indication in her chart or elsewhere that she had epilepsy. The paragraph in which epilepsy is mentioned is identical to the paragraphs in P-4's and P-5's N-648 forms mentioning epilepsy.

52. On August 10, 2014, Respondent saw P-6 for pain in the left side of her stomach for three days and dry mouth for three weeks. The reason for the visit is described as "LLQ area pain, dry and bitter mouth at early morning." Her glucose level was described as 220 and she had a sensation of burning on her feet. Respondent did not document testing of vibratory or touch sensation of the lower extremities. Pulses on the feet were noted to be normal. The abdominal exam was unremarkable. Respondent's diagnoses included abdominal pain, LLQ, and type 2 diabetes, uncomplicated and controlled, with neurological complications and polyneuropathy. Medications prescribed included Cipro,[15] omeprazole, and gabapentin.[16]

53. Respondent saw P-6 again on December 4, 2014, for a follow up visit. There was no history documented and no mention of dizziness. The physical examination was unremarkable

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[14] Flagyl, a trade name for metronidazole, is an antibiotic used to treat bacterial infections of the vagina, stomach, skin, joints, and respiratory tract. It is a dangerous drug as defined in section 4022.

[15] Cipro, a trade name for ciprofloxacin, is a fluoroquinolone antibiotic that fights bacteria in the body. Ciprofloxacin is used to treat urinary and abdominal bacterial infections. It is a dangerous drug as defined in section 4022.

[16] Gabapentin, which is also sold under the trade name Neurontin, is an anti-epileptic medication which affects chemicals and nerves in the body that are involved in seizures and some types of pain. Gabapentin is used to treat neuropathy pain in diabetics and other conditions where nerves are damaged and causing pain. It is a dangerous drug as defined in section 4022.

except for a slight elevation of blood pressure. P-6's glucose level was 248. Respondent's assessments included type 2 diabetes mellitus, uncomplicated and controlled, and vertigo.

SIXTH CAUSE FOR DISCIPLINE
(Gross Negligence, Repeated Negligent Acts, Lack of Knowledge, Failure to Maintain Adequate Records)

54. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) (gross negligence), (c) (repeated negligent acts), and/or (d) (incompetence), and section 2266 (inadequate records) of the Code in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent failed to include complete medical histories and accurate medication lists for Patient P-6.

B. Respondent did not adequately evaluate P-6 when she presented with "frequent acidity on stomach" on June 12, 2012, failing to ask and document even the most basic historical features of P-6's concern, failing to perform an appropriate physical examination and diagnostic testing, and prescribing an NSAID in the setting of undiagnosed upper abdominal pain which could worsen several potential conditions.

C. Respondent failed to address P-6's elevated blood glucose and high hemoglobin A1C test results over the course of his treatment of her by recognizing that her diabetes was not controlled, discussing the findings with her, and titrating her medication.

D. When P-6 presented on January 20, 2013, with a head injury from a fall, Respondent did not perform a full evaluation, documenting a history of events surrounding the fall and information about P-6's dizziness including when it began, any triggering factors, and other important historical information.

E. When P-6 presented with a history of three days of left lower quadrant abdominal pain on April 6, 2014, Respondent failed to fully evaluate the complaint and, with an extremely sparse history and a normal physical examination of the abdomen, assumed P-6 had colitis and prescribed Flagyl which, had there been an intra-abdominal infection, would normally have been prescribed together with ciprofloxacin.

F. When P-6 presented on February 17, 2013, complaining that both hands had been

trembling for two months, Respondent's history was incomplete, his physical exam documentation was vague and did not reflect testing for classic features of Parkinson's Disease which Respondent indicated he wanted to rule out, and he failed to follow up on his referral to a neurologist or on P-6's symptoms.

G. When P-6 presented on August 10, 2014, with an elevated blood glucose level of 220 and complaining of three weeks of dry mouth, which may indicate severe fluid balance abnormalities due to uncontrolled diabetes, Respondent did not take a sufficient history to determine the cause of the symptom, failed to document a discussion of P-6's adherence or non-adherence to the diabetes treatment plans, and failed to adjust or intensify his treatment of P-6's diabetes.

H. When P-6 presented on August 10, 2014, with burning of the feet, which can represent nerve damage from chronically elevated blood glucose in an uncontrolled diabetic, he failed to perform a standard foot exam.

I. Respondent failed to arrange for a neurological work up for P-6 despite his having administered an MMSE to her the results of which indicated a severe cognitive impairment.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board issue a decision:

1. Revoking or suspending Physician Assistant License Number PA13931, issued to Lauro Ivan Arteaga, P.A.;

2. Ordering Lauro Ivan Arteaga, P.A., if placed on probation, to pay the Physician Assistant Board the costs of probation monitoring, pursuant to Business and Professions Code section 3527, subdivision (f);

3. Ordering Lauro Ivan Arteaga, P.A. to pay the Physician Assistant Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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4. Taking such other and further action as deemed necessary and proper.

DATED: February 1, 2017

MAUREEN L. FORSYTH
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

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